

MNHG Health Plan Benefit Comparison

June 1, 2021 to May 31, 2022

Effective 06-01-2021

changes and/or clarifications in red font

BENEFIT	TUFTS HEALTH PLAN			FALLON COMMUNITY HEALTH PLAN	HARVARD PILGRIM HEALTH CARE		
	ADVANTAGE HMO	ADVANTAGE PPO		SELECTCARE & DIRECTCARE	HMO	PPO	
		In-Network	Out-of-Network	HMO PLANS*see footnote		IN-NETWORK	OUT-OF-NETWORK
Deductible - applies to: <i>In-patient Admissions; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to routine office visits or pharmacy. Per plan year (June 1 to May 31) - See plan document for full details</i>	\$300 per member not to exceed \$900 per family	\$300 per member not to exceed \$900 per	\$400 per member \$800 per family	\$300 per member not to exceed \$900 per family	\$300 per member not to exceed \$900 per	\$300 per member not to exceed \$900 per	\$400 per member \$800 per family
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay \$0 for remainder of plan year. <i>NOTE: prescription out-of-pocket maximums added effective June 1, 2015 as required by ACA (in-network only).</i>	Medical: \$2,000 per member \$4,000 per family Prescription: \$3,000 per member \$6,000 per family	Medical: \$2,000 per member \$4,000 per family Prescription: \$3,000 per member \$6,000 per family	Medical only: \$3,000 per member \$6,000 per Family	Medical & Prescription Combined \$2,000 per member \$4,000 per family	Medical: \$2,000 per member \$4,000 per family Prescription: \$3,000 per member \$6,000 per family	Medical: \$2,000 per member \$4,000 per family Prescription: \$3,000 per member \$6,000 per family	Medical only: \$3,000 per member
Lifetime Benefit Maximum	None	None	None	None	None	None	None
INPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and special services) - Deductible Applies	\$500 copay per admission	\$500 copay per admission	20% coinsurance*	\$500 copay per admission, then deductible for medical inpatient; substance abuse and mental health inpatient visits are covered in full	\$500 copay per admission then deductible for medical inpatient; substance abuse and mental health inpatient visits are covered in full	\$500 copay per admission	20% coinsurance*
Physician Services	Nothing	Nothing	20% coinsurance*	Nothing	Nothing	Nothing	20% coinsurance*
Skilled Nursing Facility - Deductible Applies	No copay to 100 days per plan year benefit maximum, when medically necessary	No copay to 100 days per plan year benefit maximum, when medically necessary	20% coinsurance* up to 100 days per plan year benefit maximum, when medically necessary	CIF after deductible , up to 100 days per plan year at a semi-private rate for each benefit	Deductible, then \$500 copay, up to 100 days per plan year at a semi-private rate for each benefit	Limit to 100 days per Plan Year - \$500 copay per admission	20% coinsurance*
Rehabilitation Hospital - Deductible Applies	No copay to 100 days per plan year benefit maximum, when medically necessary	No copay to 100 days per plan year benefit maximum, when medically necessary	20% coinsurance* up to 100 days per plan year benefit maximum, when medically necessary	CIF after deductible , up to 100 days per plan year at a semi-private rate for each benefit	Deductible, then \$500 copay, up to 60 days per plan year at a semi-private rate for each benefit	Limit to 60 days per Plan Year - \$500 copay per admission	20% coinsurance*

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		In-Network	Out-of-Network	HMO PLANS ^{*see footnote}		IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Emergency Room Visits for Emergency or Accident Care - Deductible Applies	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay, (waived if admitted)	\$100 copay, then deductible, (waived if admitted)	\$100 copay, (waived if admitted)	\$100 copay, (waived if admitted)
Emergency Room Visits for Medical Care - Deductible Applies	\$100 copay, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted	\$100 copay, then deductible, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted
Surgery - Deductible Applies	\$250 copay	\$250 copay	20% coinsurance*	\$250 copay	\$250 copay	\$250 copay	20% coinsurance*
Radiation and Chemotherapy Deductible Applies	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*	Covered in full (after the deductible has been met)	Covered in full	Covered in full	20% coinsurance*
Diagnostic X-ray and Lab - Deductible Applies	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*
Routine Colonoscopy (without surgery)	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
High Cost Radiology (MRI, CT & PET) - Deductible Applies	\$100 copay	\$100 copay	20% coinsurance*	\$100 copay, then deductible	Deductible, then \$100 copay	\$100 copay	20% coinsurance*
Hemodialysis - Deductible Applies	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*
Physical Therapy	Covered in full after deductible. 30 visit limit per plan year.	Covered in full after deductible. 30 visit limit per plan year.	20% Coinsurance * 30 visit limit per plan year.	\$20 co-pay up to 60 visits per benefit policy	\$20 co-pay up to 30 visits per plan year	30 visits per Plan Year - \$20 copay per visit	20% coinsurance* 30 visits per plan year
Visiting Nurse Home Health Care - Deductible applies where noted	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*
Dental Benefit	No coverage	No coverage	No coverage	\$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.	No coverage	No coverage	No coverage

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		In-Network YOU PAY	Out-of-Network YOU PAY			IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY
PHYSICIAN'S OFFICE							
Surgery - NO Deductible	Surgery in a Physician's office is CIF once the deductible has been met	Surgery in a Physician's office is CIF once the deductible has been met	20% coinsurance*	\$20 PCP copay and \$45 Specialist copay	Copay Level 1 provider : \$20 per visit Copay Level 2 provider : \$45 per visit	Copay Level 1 provider : \$20 per visit Copay Level 2 provider : \$45 per visit	20% coinsurance*
Adult Preventative Exam <i>(includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
PCP Medical Care/ Mental Health Care/ Substance Abuse Care	\$20 copay	\$20 copay	20% coinsurance*	\$20 copay	\$20 copay	\$20 copay	20% coinsurance*
Well Child Care <i>(includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay (including routine physical exams, immunizations, annual eye exam, school, camp, sports)	\$0 copay (including routine physical exams, immunizations, school, camp, sports)	\$0 copay (including routine physical exams, immunizations, school, camp, sports)	20% coinsurance*
Routine GYN Exam <i>(one per calendar year, includes preventative lab tests)</i>	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
Routine Mammogram	\$0 copay	\$0 copay	20% coinsurance*	\$0 copay	\$0 copay	\$0 copay	20% coinsurance*
Routine Vision Exam	\$20 copay (once per plan year)	\$20 copay (once per plan year)	20% coinsurance* (once per plan year)	Covered in full (once every 12 months)	Limited 1 per Plan Year No Charge	Limited 1 per Plan Year No Charge	20% coinsurance*
Routine Maternity Care Office Visits	Prenatal and Postpartum care covered in full	Prenatal and Postpartum care covered in full	20% coinsurance	Prenatal: Covered in full ; Postnatal: Cover in full after deductible	No charge for routine	No charge for routine	20% coinsurance
Specialist Office Visit	\$45 copay	\$45 copay	20% coinsurance*	\$45 copay	\$45 copay	\$45 copay	20% coinsurance*
OTHER OUTPATIENT							
Durable Medical Equipment - Deductible applies where noted	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	30% coinsurance, after deductible	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	Covered in full (after the deductible has been met)	20% coinsurance*
Ambulance	\$0 copay	\$0 copay	Nothing for accident or emergency; Non Emergency Transport - 20% Coinsurance*	\$100 copay when medically necessary	\$0 copay	\$0 copay	\$0 copay
Routine Pediatric Dental	Children under age 12: Periodic oral exam, cleaning, fluoride, bitewing x-rays; once every 6 mos. Must choose a dentist from directory	Children under age 12: Periodic oral exam, cleaning, fluoride, bitewing x-rays; once every 6 mos. Must choose a dentist from directory	No coverage	\$10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & fluoride treatment.	Covered in full: Preventive care for children under age 12 2 visits per member per calendar year including exam, cleaning, x-rays, & fluoride treatment.	Deductible, then 20% coinsurance
Chiropractor Visits - Deductible applies where noted	Covered in full after deductible. 12 visit limit per plan year	Covered in full after deductible. 12 visit limit per plan year	20% coinsurance after deductible. 12 visit limit per plan year	\$20 copay, maximum of 12 visits per plan year	No coverage	No coverage	No coverage

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		In-Network	Out-of-Network			IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: (90 day supply) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: (90 day) Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay	Retail: (30 day supply) Tier 1: \$10.00 copay Tier 2: \$30.00 copay Tier 3: \$65.00 copay Mail Order: Tier 1: \$25.00 copay Tier 2: \$75.00 copay Tier 3: \$165.00 copay
Fitness & Wellness Benefits	Fitness reimbursement up to \$150 per subscriber at a Fitness club or facility per plan year. Eligibility after 4 consecutive months of membership with both THP and the qualifying health and fitness club. The reimbursement criteria will be expanded to include organized group exercise classes. Classes must be provided within a studio or fitness facility. This expansion excludes dance classes, and any classes received in a home or resident setting. Discounts also available at participating health clubs. See plan materials for details	Fitness reimbursement up to \$150 per subscriber at a Fitness club or facility per plan year. Eligibility after 4 consecutive months of membership with both THP and the qualifying health and fitness club. The reimbursement criteria will be expanded to include organized group exercise classes. Classes must be provided within a studio or fitness facility. This expansion excludes dance classes, and any classes received in a home or resident setting. Discounts also available at participating health clubs. See plan materials for details	Fitness reimbursement up to \$150 per subscriber at a Fitness club or facility per plan year. Eligibility after 4 consecutive months of membership with both THP and the qualifying health and fitness club. The reimbursement criteria will be expanded to include organized group exercise classes. Classes must be provided within a studio or fitness facility. This expansion excludes dance classes, and any classes received in a home or resident setting. Discounts also available at participating health clubs. See plan materials for details	It Fits! Program reimburses families on Select Care up to \$400 per family contract (\$200 for individual contracts)and Direct Care members up to \$500 per family contract (\$250 for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment. WELLNESS - The Healthy Health Plan – An online wellness program that rewards subscribers and their covered spouses for being, and becoming, healthy. Members simply visit fallonhealth.org/healthyhealthplan , fill out the health assessment, and if eligible, they will receive up to \$100 . Members that need a little help getting healthier may participate in interactive health tools, health coaching, and more. Members that are already in excellent health also have access to the same tools to assist them in staying healthy.	Up to \$150 reimbursement per calendar year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.	Up to \$150 reimbursement per calendar year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.	Up to \$150 reimbursement per calendar year. Must be an active member of HPHC for at least 4 months and a member of any qualified health & fitness club for 4 consecutive months.
*After Deductible							
^FCHP SELECTCARE AND DIRECTCARE PROVIDER NETWORKS - SEE BELOW							
Select Care is an expansive network that includes physician practices, community-based hospitals and medical facilities across Massachusetts and southern New Hampshire. Select Care offers greater choice at a competitive price. The Select Care service area includes all of Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties. With more than 35,000 providers, Select Care means more options and choices for you and your family.							
Direct Care is a limited provider network, including premier provider groups and community hospitals offering high-quality care at an affordable premium. These providers are chosen for their medical excellence, patient access and innovation. There are more than 22,000 participating providers in the Direct Care network.							
As a Direct Care member, if you ever should need a second opinion or the specialized expertise of Boston research and teaching hospitals, Fallon Direct Care offers access through our exclusive Peace of Mind Program™.							
These pages summarize benefits of the plan(s). The Subscriber Certificate(s) & applicable riders define the terms & conditions of these benefits in greater detail. Should any questions arise, the certificate(s) & riders will govern.							